

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03495

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>72 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE COFFIN AYRES</u>		4. DATE OF DEATH Month Day Year <u>MAR. 8 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 28, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED COFFIN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GRIFFIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MR. JAMES A. AYRES</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Pulmonary Edema + Anoxemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Dis. Myocarditis</u> DUE TO <u>CORONARY</u> (c) <u>Coronary Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 yrs</u> <u>12 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1947</u> to <u>Mar 8 1957</u> , that I last saw the deceased alive on <u>10 AM 1957</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Skinner R. Rappun</u> M.D. <u>Berlin, Md</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>3/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dona R. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Hayward</u>	

BUREAU V. S.

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03496

## CERTIFICATE OF DEATH

03496

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>30 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 MAIN ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN W. BENNETT</u>				4. DATE OF DEATH Month Day Year <u>March 29 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 6, 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PEN N.</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>717-07-9065</u>			
17. INFORMANT <u>MRS B.W. BENNETT</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> <u>431X</u> DUE TO (b) <u>74y peritonism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 1, 1955</u> to <u>March 19, 1957</u> , that I last saw the deceased alive on <u>March 19, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
PHYSICIAN'S NAME (Type) <u>Clifford E. Schott</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BARRETTS CHAPEL</u>		22d. LOCATION (City, town, or county) <u>FREDRICA</u> (State) <u>DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE 3-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Helen G. Hayward</u>	

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1/22/22		MEMPHIS, TENN.		MEMPHIS		TENN.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.		U.S.A.		4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		NATURAL		4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.		U.S.A.		4/4/68		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.		U.S.A.		4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.		U.S.A.		4/4/68		MEMPHIS, TENN.		MEMPHIS		TENN.	

BUREAU V. S.

MAR 26 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03497 355  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>25 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO BERLIN</u>	
		d. STREET ADDRESS <u>100 C. HIGHWAY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD RAYMOND BROLLIAR</u>		4. DATE OF DEATH Month Day Year <u>MAR. 6 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 8, 1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>JOPLIN, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS J. BROLLIAR</u>		14. MOTHER'S MAIDEN NAME <u>EMMA MOORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. FLORENCE BROLLIAR</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 AM</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan - 1957</u> , to <u>March 6, 1957</u> , that I last saw the deceased alive on <u>March 6, 1957</u> , and that death occurred at <u>1030 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. R. Law</u>		ADDRESS (Street, city or town, state) <u>Berlin Md.</u>	
DATE SIGNED <u>3-7-1957</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burboye</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>3-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	

**BUREAU A. S.**

MAR 11 1957

RECEIVED



# CERTIFICATE OF DEATH

Reg. Dist. No. 355

03498

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>		c. LENGTH OF STAY IN 1b <b>20 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1 BALTO. AVE</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH THOMAS BRYAN</b>		4. DATE OF DEATH Month <b>MAR</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27, 1893</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>PALEIGH N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES BRYAN</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE SCHONWALD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MRS. J.T. BRYAN, OCEAN CITY MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema, vesicular</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic CVD with coronary angina &amp; chronic failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>59 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1956</b> , to <b>Mar 18, 1957</b> , that I last saw the deceased alive on <b>Mar 18, 1957</b> , and that death occurred at <b>7:25 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. Townsend Jr</b>		DATE SIGNED <b>MAR 19 1957</b>	
PHYSICIAN'S NAME (Type) <b>FRANCIS JAMES TOWNSEND JR</b>		M.D. <b>Ocean City, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna B. Burban</b>		ADDRESS <b>Berlin Md</b>	
24a. REC'D BY REGISTRAR DATE <b>3-20-57</b>		24b. REGISTRAR'S SIGNATURE <b>Helen F. Howard</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

MAR 22 1957

RECEIVED



03499

## CERTIFICATE OF DEATH

03499

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>				c. LENGTH OF STAY IN 1b <b>6 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>---</b> Last <b>Carey</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1886</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Carey</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-34-9576</b>		17. INFORMANT Address <b>Mrs Lillie F. Carey, Stockton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pleural Effusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1957</b> , to <b>March 14, 1957</b> , that I last saw the deceased alive on <b>March 12, 1957</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Church, Virginia</b> DATE SIGNED <b>3/15/57</b>							
ACTUAL SIGNATURE <b>C.E. Critcher</b>				PHYSICIAN'S NAME (Type) <b>New Church Va</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Porterville M.E. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Stockton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry L. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. RECEIVED BY REGISTRAR <b>March 16 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clayton Coopers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

**BUREAU V. S.**

MAR 18 1957

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03500

## 03490 CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Pocomoke City</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>426 Oxford</u>				STREET ADDRESS <u>426 Oxford</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elizabeth</u> (Middle) <u>Collier</u> (Last)				(Month) <u>March</u> (Day) <u>26</u> (Year) <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 17, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Logan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-3635</u>		17. INFORMANT & ADDRESS <u>Mrs. Garnett Smullen Pocomoke, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0 Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>						<u>3 mths</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						<u>3 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Ac Pulmonary Edema</u>						<u>3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/22</u> , 19 <u>57</u> , to <u>March 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 25</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul A. Dwyer</u> M.D.				ADDRESS (Street, city, town, state) <u>Pocomoke Maryland</u>		DATE SIGNED <u>3/26/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/31/57</u>		NAME OF CEMETERY OR CREMATORY <u>Halls Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Apr. 2, 1957</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		ADDRESS	

# CERTIFICATE OF DEATH

FILE NO. 341

1. USUAL RESIDENCE (SHOW IN CASE OF DEATH)

2. DATE OF DEATH

MARYLAND

COUNTY OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. MEDICAL EXAMINATION

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF DEPUTY SHERIFF

17. SIGNATURE OF JAILER

18. SIGNATURE OF WARDEN

BUREAU V. 3

APR 4 1957

RECEIVED

ENCLOSURE

03500

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>				c. LENGTH OF STAY IN 1b <u>4 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ocean Down Race Track</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Presetta</u> Middle <u>P.</u> Last <u>Cummiford</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26 - 1868</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Friedrich Hainger</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Dickhaut</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr Lloyd Cummiford, Snow Hill md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>6 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Feb. 9</u> , 19 <u>57</u> , to <u>March 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. J. O. Wainell</u>				M.D. <u>Commerce St. Berlin, md</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Ridge Cemetery</u>		22d. LOCATION (City, town, and county) <u>Berlin, Worcester County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Cummiford</u>				ADDRESS <u>Snow Hill, md</u>		24. REC'D BY REGISTRAR DATE <u>18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Klen P. Brown</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
COUNTY		STATE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		MAR 18 1957	

BUREAU V. 3

MAR 18 1957

RECEIVED



03491

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>613 Walnut Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Landes</u> Last <u>Eutsler</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1860</u>		9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Abraham Landes</u>			
14. MOTHER'S MAIDEN NAME <u>Isabelle Finley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs A. D. Merrill Sr., Pocomoke, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lymphadenitis &amp; Anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Market St., Pocomoke City, Maryland</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 15, 1957</u> to <u>March 16, 1957</u> that I last saw the deceased alive on <u>March 15, 1957</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Market St., Pocomoke City, Maryland</u>			
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u> M.D.				DATE SIGNED <u>March 20, 1957</u>			
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius Sr.</u>				<u>Market St., Pocomoke City, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edge Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Charles Town, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 20 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Anne White</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 20 1957

RECEIVED

03492

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Market Street</b>				d. STREET ADDRESS <b>1 Market Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Roy</b> Middle <b>W.</b> Last <b>Figgs</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1884</b>		9. AGE (In years last birthday) <b>72</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William L. Figgs</b>				14. MOTHER'S MAIDEN NAME <b>Jane Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mrs Rosetta Figgs, Pocomoke, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anemia, severe</b> DUE TO (c) <b>Primary Carcinoma of Prostate</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension of Rt. Kidney</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Pocomoke</b>		20g. (County) <b>Worcester</b>		20h. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>1947</b> to <b>8 March</b> , 1957, that I last saw the deceased alive on <b>7 March</b> , 1957, and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>N.E. Sartorius, Jr.</b>		M.D. <b>114 Market St., Pocomoke, Md.</b>		DATE SIGNED <b>114 Market St., Pocomoke City, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>N.E. Sartorius, Jr. M.D.</b>		ADDRESS <b>114 Market St., Pocomoke City, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem M.E. Cemetery</b>			
22d. LOCATION (City, town, or county) <b>Pocomoke City, Maryland</b>		22e. (State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Watson</b>		ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 11 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Anne White</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF

MARYLAND

CITY OF BALTIMORE

WARD OF BALTIMORE

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

MAR 11 1957

RECEIVED

03501

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>BERLIN-D.CITY RD</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ROBERT J. FISHER</b>				4. DATE OF DEATH <b>MAR. 26 1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years lost birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN MD RFD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. RFD.</b>	
13. FATHER'S NAME <b>John Howard Fisher</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET BAKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs R. J. Fisher Berlin Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Kimmel stiel-Wilson Syndrome</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs 10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1947</b> , to <b>MAY 24, 1957</b> , that I last saw the deceased alive on <b>MAY 24, 1957</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. H. Thomas</b>				ADDRESS (Street, city or town, state) <b>Chesapeake, Md</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>W. H. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burley</b>				ADDRESS <b>Berlin Md</b>		24a. REC'D BY REGISTRAR <b>DATE 3-31-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Helen F. Hayward</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 3.

APR 2 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03502

03505 357  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>9 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R. 2 D. No 2</u>		d. STREET ADDRESS <u>R. 2 D. - No 2</u>	
3. NAME OF DECEASED (Type or print) <u>William Walter Frisher</u>		4. DATE OF DEATH <u>March 5 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 - 1914</u>
9. AGE (In years last birthday) <u>42 9/19 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woods Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber</u>	
11. BIRTHPLACE (State or foreign country) <u>Nassau, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Frisher Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Upsher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>228-14-5955</u>	
17. INFORMANT <u>Rosal Holland</u>		Address <u>Snow Hill Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ever instantly</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial March 9/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin Dennis</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>Alvin Dennis</u>		24b. REGISTRAR'S SIGNATURE <u>Alvin Dennis</u>	

STANDARD STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		PLACE OF BIRTH _____	
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		AGE _____	
OCCUPATION _____		DATE OF DEATH _____	
PLACE OF DEATH _____		TIME OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
PRINTED NAME OF EXAMINER _____		PRINTED NAME OF WITNESS _____	
TITLE OF EXAMINER _____		TITLE OF WITNESS _____	
ADDRESS OF EXAMINER _____		ADDRESS OF WITNESS _____	
CITY OF EXAMINER _____		CITY OF WITNESS _____	
STATE OF EXAMINER _____		STATE OF WITNESS _____	
COUNTY OF EXAMINER _____		COUNTY OF WITNESS _____	
ZIP CODE OF EXAMINER _____		ZIP CODE OF WITNESS _____	

RECEIVED  
 MAR 7 1957  
 BUREAU V. S.

03493

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>714 Cedar Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bertie A. Ford</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 7, 1878</b>		9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>57</b>	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Reid</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Lambertson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Miss Alma Ford, Philadelphia, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>200X</b> (b) <b>Coronary Artery Disease</b> DUE TO <b>200X</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>d. Diabetes Mellitus &amp; Hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>49</b> , to <b>Mar 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 2</b> , 19 <b>57</b> , and that death occurred at <b>830 p. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles W. Trader</b>		ADDRESS (Street, city or town, state) <b>Market St., Pocomoke Md 3-4-57</b>					
PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>		DATE SIGNED <b>Mar 2 1957</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethany M.P. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke, Md</b>		24a. REC'D BY REGISTRAR <b>Mar 8 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ann White</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF HEALTH DEPARTMENT		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF CITY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF FEDERAL CLERK		27. SIGNATURE OF POSTAL CLERK	
28. SIGNATURE OF AIR FORCE CLERK		29. SIGNATURE OF NAVY CLERK		30. SIGNATURE OF MARINE CLERK	
31. SIGNATURE OF ARMY CLERK		32. SIGNATURE OF COAST GUARD CLERK		33. SIGNATURE OF CUSTOMS CLERK	
34. SIGNATURE OF INSURANCE CLERK		35. SIGNATURE OF BANK CLERK		36. SIGNATURE OF POST OFFICE CLERK	
37. SIGNATURE OF RAILROAD CLERK		38. SIGNATURE OF STEAMSHIP CLERK		39. SIGNATURE OF AIRLINE CLERK	
40. SIGNATURE OF TRUCKING CLERK		41. SIGNATURE OF WAREHOUSE CLERK		42. SIGNATURE OF FACTORY CLERK	
43. SIGNATURE OF MINING CLERK		44. SIGNATURE OF AGRICULTURE CLERK		45. SIGNATURE OF FISHERY CLERK	
46. SIGNATURE OF FORESTRY CLERK		47. SIGNATURE OF HUNTING CLERK		48. SIGNATURE OF FISHING CLERK	
49. SIGNATURE OF GOLFING CLERK		50. SIGNATURE OF BOATING CLERK		51. SIGNATURE OF CAMPING CLERK	
52. SIGNATURE OF TRAVELING CLERK		53. SIGNATURE OF VISITING CLERK		54. SIGNATURE OF STAYING CLERK	
55. SIGNATURE OF EATING CLERK		56. SIGNATURE OF DRINKING CLERK		57. SIGNATURE OF SHOPPING CLERK	
58. SIGNATURE OF WORKING CLERK		59. SIGNATURE OF PLAYING CLERK		60. SIGNATURE OF LEARNING CLERK	
61. SIGNATURE OF TEACHING CLERK		62. SIGNATURE OF STUDYING CLERK		63. SIGNATURE OF READING CLERK	
64. SIGNATURE OF WRITING CLERK		65. SIGNATURE OF SPEAKING CLERK		66. SIGNATURE OF LISTENING CLERK	
67. SIGNATURE OF THINKING CLERK		68. SIGNATURE OF FEELING CLERK		69. SIGNATURE OF MOVING CLERK	
70. SIGNATURE OF BEING CLERK		71. SIGNATURE OF SEEMING CLERK		72. SIGNATURE OF SOUNDING CLERK	
73. SIGNATURE OF SMELLING CLERK		74. SIGNATURE OF TASTING CLERK		75. SIGNATURE OF TOUCHING CLERK	
76. SIGNATURE OF FEELING CLERK		77. SIGNATURE OF MOVING CLERK		78. SIGNATURE OF BEING CLERK	
79. SIGNATURE OF SEEMING CLERK		80. SIGNATURE OF SOUNDING CLERK		81. SIGNATURE OF SMELLING CLERK	
82. SIGNATURE OF TASTING CLERK		83. SIGNATURE OF TOUCHING CLERK		84. SIGNATURE OF FEELING CLERK	
85. SIGNATURE OF MOVING CLERK		86. SIGNATURE OF BEING CLERK		87. SIGNATURE OF SEEMING CLERK	
88. SIGNATURE OF SOUNDING CLERK		89. SIGNATURE OF SMELLING CLERK		90. SIGNATURE OF TASTING CLERK	
91. SIGNATURE OF TOUCHING CLERK		92. SIGNATURE OF FEELING CLERK		93. SIGNATURE OF MOVING CLERK	
94. SIGNATURE OF BEING CLERK		95. SIGNATURE OF SEEMING CLERK		96. SIGNATURE OF SOUNDING CLERK	
97. SIGNATURE OF SMELLING CLERK		98. SIGNATURE OF TASTING CLERK		99. SIGNATURE OF TOUCHING CLERK	
100. SIGNATURE OF FEELING CLERK		101. SIGNATURE OF MOVING CLERK		102. SIGNATURE OF BEING CLERK	
103. SIGNATURE OF SEEMING CLERK		104. SIGNATURE OF SOUNDING CLERK		105. SIGNATURE OF SMELLING CLERK	
106. SIGNATURE OF TASTING CLERK		107. SIGNATURE OF TOUCHING CLERK		108. SIGNATURE OF FEELING CLERK	
109. SIGNATURE OF MOVING CLERK		110. SIGNATURE OF BEING CLERK		111. SIGNATURE OF SEEMING CLERK	
112. SIGNATURE OF SOUNDING CLERK		113. SIGNATURE OF SMELLING CLERK		114. SIGNATURE OF TASTING CLERK	
115. SIGNATURE OF TOUCHING CLERK		116. SIGNATURE OF FEELING CLERK		117. SIGNATURE OF MOVING CLERK	
118. SIGNATURE OF BEING CLERK		119. SIGNATURE OF SEEMING CLERK		120. SIGNATURE OF SOUNDING CLERK	
121. SIGNATURE OF SMELLING CLERK		122. SIGNATURE OF TASTING CLERK		123. SIGNATURE OF TOUCHING CLERK	
124. SIGNATURE OF FEELING CLERK		125. SIGNATURE OF MOVING CLERK		126. SIGNATURE OF BEING CLERK	
127. SIGNATURE OF SEEMING CLERK		128. SIGNATURE OF SOUNDING CLERK		129. SIGNATURE OF SMELLING CLERK	
130. SIGNATURE OF TASTING CLERK		131. SIGNATURE OF TOUCHING CLERK		132. SIGNATURE OF FEELING CLERK	
133. SIGNATURE OF MOVING CLERK		134. SIGNATURE OF BEING CLERK		135. SIGNATURE OF SEEMING CLERK	
136. SIGNATURE OF SOUNDING CLERK		137. SIGNATURE OF SMELLING CLERK		138. SIGNATURE OF TASTING CLERK	
139. SIGNATURE OF TOUCHING CLERK		140. SIGNATURE OF FEELING CLERK		141. SIGNATURE OF MOVING CLERK	
142. SIGNATURE OF BEING CLERK		143. SIGNATURE OF SEEMING CLERK		144. SIGNATURE OF SOUNDING CLERK	
145. SIGNATURE OF SMELLING CLERK		146. SIGNATURE OF TASTING CLERK		147. SIGNATURE OF TOUCHING CLERK	
148. SIGNATURE OF FEELING CLERK		149. SIGNATURE OF MOVING CLERK		150. SIGNATURE OF BEING CLERK	
151. SIGNATURE OF SEEMING CLERK		152. SIGNATURE OF SOUNDING CLERK		153. SIGNATURE OF SMELLING CLERK	
154. SIGNATURE OF TASTING CLERK		155. SIGNATURE OF TOUCHING CLERK		156. SIGNATURE OF FEELING CLERK	
157. SIGNATURE OF MOVING CLERK		158. SIGNATURE OF BEING CLERK		159. SIGNATURE OF SEEMING CLERK	
160. SIGNATURE OF SOUNDING CLERK		161. SIGNATURE OF SMELLING CLERK		162. SIGNATURE OF TASTING CLERK	
163. SIGNATURE OF TOUCHING CLERK		164. SIGNATURE OF FEELING CLERK		165. SIGNATURE OF MOVING CLERK	
166. SIGNATURE OF BEING CLERK		167. SIGNATURE OF SEEMING CLERK		168. SIGNATURE OF SOUNDING CLERK	
169. SIGNATURE OF SMELLING CLERK		170. SIGNATURE OF TASTING CLERK		171. SIGNATURE OF TOUCHING CLERK	
172. SIGNATURE OF FEELING CLERK		173. SIGNATURE OF MOVING CLERK		174. SIGNATURE OF BEING CLERK	
175. SIGNATURE OF SEEMING CLERK		176. SIGNATURE OF SOUNDING CLERK		177. SIGNATURE OF SMELLING CLERK	
178. SIGNATURE OF TASTING CLERK		179. SIGNATURE OF TOUCHING CLERK		180. SIGNATURE OF FEELING CLERK	
181. SIGNATURE OF MOVING CLERK		182. SIGNATURE OF BEING CLERK		183. SIGNATURE OF SEEMING CLERK	
184. SIGNATURE OF SOUNDING CLERK		185. SIGNATURE OF SMELLING CLERK		186. SIGNATURE OF TASTING CLERK	
187. SIGNATURE OF TOUCHING CLERK		188. SIGNATURE OF FEELING CLERK		189. SIGNATURE OF MOVING CLERK	
190. SIGNATURE OF BEING CLERK		191. SIGNATURE OF SEEMING CLERK		192. SIGNATURE OF SOUNDING CLERK	
193. SIGNATURE OF SMELLING CLERK		194. SIGNATURE OF TASTING CLERK		195. SIGNATURE OF TOUCHING CLERK	
196. SIGNATURE OF FEELING CLERK		197. SIGNATURE OF MOVING CLERK		198. SIGNATURE OF BEING CLERK	
199. SIGNATURE OF SEEMING CLERK		200. SIGNATURE OF SOUNDING CLERK		201. SIGNATURE OF SMELLING CLERK	
202. SIGNATURE OF TASTING CLERK		203. SIGNATURE OF TOUCHING CLERK		204. SIGNATURE OF FEELING CLERK	
205. SIGNATURE OF MOVING CLERK		206. SIGNATURE OF BEING CLERK		207. SIGNATURE OF SEEMING CLERK	
208. SIGNATURE OF SOUNDING CLERK		209. SIGNATURE OF SMELLING CLERK		210. SIGNATURE OF TASTING CLERK	
211. SIGNATURE OF TOUCHING CLERK		212. SIGNATURE OF FEELING CLERK		213. SIGNATURE OF MOVING CLERK	
214. SIGNATURE OF BEING CLERK		215. SIGNATURE OF SEEMING CLERK		216. SIGNATURE OF SOUNDING CLERK	
217. SIGNATURE OF SMELLING CLERK		218. SIGNATURE OF TASTING CLERK		219. SIGNATURE OF TOUCHING CLERK	
220. SIGNATURE OF FEELING CLERK		221. SIGNATURE OF MOVING CLERK		222. SIGNATURE OF BEING CLERK	
223. SIGNATURE OF SEEMING CLERK		224. SIGNATURE OF SOUNDING CLERK		225. SIGNATURE OF SMELLING CLERK	
226. SIGNATURE OF TASTING CLERK		227. SIGNATURE OF TOUCHING CLERK		228. SIGNATURE OF FEELING CLERK	
229. SIGNATURE OF MOVING CLERK		230. SIGNATURE OF BEING CLERK		231. SIGNATURE OF SEEMING CLERK	
232. SIGNATURE OF SOUNDING CLERK		233. SIGNATURE OF SMELLING CLERK		234. SIGNATURE OF TASTING CLERK	
235. SIGNATURE OF TOUCHING CLERK		236. SIGNATURE OF FEELING CLERK		237. SIGNATURE OF MOVING CLERK	
238. SIGNATURE OF BEING CLERK		239. SIGNATURE OF SEEMING CLERK		240. SIGNATURE OF SOUNDING CLERK	
241. SIGNATURE OF SMELLING CLERK		242. SIGNATURE OF TASTING CLERK		243. SIGNATURE OF TOUCHING CLERK	
244. SIGNATURE OF FEELING CLERK		245. SIGNATURE OF MOVING CLERK		246. SIGNATURE OF BEING CLERK	
247. SIGNATURE OF SEEMING CLERK		248. SIGNATURE OF SOUNDING CLERK		249. SIGNATURE OF SMELLING CLERK	
250. SIGNATURE OF TASTING CLERK		251. SIGNATURE OF TOUCHING CLERK		252. SIGNATURE OF FEELING CLERK	
253. SIGNATURE OF MOVING CLERK		254. SIGNATURE OF BEING CLERK		255. SIGNATURE OF SEEMING CLERK	
256. SIGNATURE OF SOUNDING CLERK		257. SIGNATURE OF SMELLING CLERK		258. SIGNATURE OF TASTING CLERK	
259. SIGNATURE OF TOUCHING CLERK		260. SIGNATURE OF FEELING CLERK		261. SIGNATURE OF MOVING CLERK	
262. SIGNATURE OF BEING CLERK		263. SIGNATURE OF SEEMING CLERK		264. SIGNATURE OF SOUNDING CLERK	
265. SIGNATURE OF SMELLING CLERK		266. SIGNATURE OF TASTING CLERK		267. SIGNATURE OF TOUCHING CLERK	
268. SIGNATURE OF FEELING CLERK		269. SIGNATURE OF MOVING CLERK		270. SIGNATURE OF BEING CLERK	
271. SIGNATURE OF SEEMING CLERK		272. SIGNATURE OF SOUNDING CLERK		273. SIGNATURE OF SMELLING CLERK	
274. SIGNATURE OF TASTING CLERK		275. SIGNATURE OF TOUCHING CLERK		276. SIGNATURE OF FEELING CLERK	
277. SIGNATURE OF MOVING CLERK		278. SIGNATURE OF BEING CLERK		279. SIGNATURE OF SEEMING CLERK	
280. SIGNATURE OF SOUNDING CLERK		281. SIGNATURE OF SMELLING CLERK		282. SIGNATURE OF TASTING CLERK	
283. SIGNATURE OF TOUCHING CLERK		284. SIGNATURE OF FEELING CLERK		285. SIGNATURE OF MOVING CLERK	
286. SIGNATURE OF BEING CLERK		287. SIGNATURE OF SEEMING CLERK		288. SIGNATURE OF SOUNDING CLERK	
289. SIGNATURE OF SMELLING CLERK		290. SIGNATURE OF TASTING CLERK		291. SIGNATURE OF TOUCHING CLERK	
292. SIGNATURE OF FEELING CLERK		293. SIGNATURE OF MOVING CLERK		294. SIGNATURE OF BEING CLERK	
295. SIGNATURE OF SEEMING CLERK		296. SIGNATURE OF SOUNDING CLERK		297. SIGNATURE OF SMELLING CLERK	
298. SIGNATURE OF TASTING CLERK		299. SIGNATURE OF TOUCHING CLERK		300. SIGNATURE OF FEELING CLERK	

BUREAU V. 1

MAR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03507

03503

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSINA</u> Middle <u>HUDSON</u> Last <u>HUDSON</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 7, 1860</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN MCCABE</u>		14. MOTHER'S MAIDEN NAME <u>JOYCE TIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MR. CALVIN HUDSON</u> Address <u>SHOWIGUE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock due to coma</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>senile arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>57</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>57</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb</u>		ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB</u>		DATE SIGNED <u>3-7-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce A. Burboys</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE 3-7-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Helen J. Hayward</u>	



**BUREAU V. S.**

MAR 11 1957

RECEIVED



03504

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>20 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 S. MAIN ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK DANA HYDE</u>				4. DATE OF DEATH Month Day Year <u>MAR. 27 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 25, 1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR, BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROADS</u>		11. BIRTHPLACE (State or foreign country) <u>WATERTOWN, WIS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PARLEY HYDE</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MR. E. BOWEN QUILLER</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular disease</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 27, 1957</u> to <u>Mar 27, 1957</u> , that I last saw the deceased alive on <u>Mar 27, 1957</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>Helen F. Hayward</u>							
ACTUAL SIGNATURE <u>H. F. Thomas</u> M.D.				PHYSICIAN'S NAME (Type) <u>H. F. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE 3-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

BUREAU V. 3

APR 2 1957

RECEIVED

03505

CERTIFICATE OF DEATH

03509

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
c. LENGTH OF STAY IN 1b <u>80 yrs.</u>				d. STREET ADDRESS <u>1 R.E.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> First <u>KATHERINE</u> Middle <u>JOHANSON</u> Last				4. DATE OF DEATH <u>MARCH</u> Month <u>6</u> Day <u>1957</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1876</u>	
				9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Berlin Md. R.F.D.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>George Smith</u>				14. MOTHER'S MAIDEN NAME <u>CLARK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Miss Mildred Johnson, Snow Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia and Inanition</u> <u>214X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CALCIFIED UTERINE MYOMA</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>56</u> , to <u>MARCH 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MARCH 5</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Bay St</u> DATE SIGNED <u>3-8-57</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>				<u>Snow Hill Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WHATCOAT</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>MAR 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eloyn Cooper</u>	



03506

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards 22x02</b>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Laura K. Ketterman</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1884</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam J. Kismore</b>				14. MOTHER'S MAIDEN NAME <b>Phoebe Bible</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Zerna Tubbs</b>		Address <b>Willards, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>434.2</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac asthma</b> (c) <b>Cardiac asthma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , 19____, to <b>3-1-57</b> , 19____, that I last saw the deceased alive on <b>3-1-57</b> , 19____, and that death occurred at <b>2P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Willards Md.</b> DATE SIGNED <b>Frank R. Lewis</b>							
ACTUAL SIGNATURE <b>Frank R. Lewis</b> M.D. <b>Willards Md.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>AR 5 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Kelen F. Hayward</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

BUREAU V. S.

MAR 5 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03507

## CERTIFICATE OF DEATH

03511

Reg. Dist. No.

351

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	c. LENGTH OF STAY IN 1b <u>12 Day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>+2 Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Adolphus</u> Middle <u>E.</u> Last <u>Linton</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dayman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Synthetic Bay</u>	9. AGE (In years last birthday) <u>59 1/2</u>
11. BIRTHPLACE (State or foreign country) <u>Sanford, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Linton</u>		14. MOTHER'S MAIDEN NAME <u>Roxie Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Mr. Darwin M. Linton</u>		Address <u>39 Lewis Rd. New Castle Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Regenerative Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>56</u> , to <u>3/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>57</u> , and that death occurred at <u>6:29</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>312 E. Market St., Snow Hill, Md.</u>	
DATE SIGNED <u>3/15/57</u>			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial March 14/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Bennis</u>		ADDRESS <u>Snow Hill, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Glenn Cooper</u>	
DATE <u>18 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 18 1957

RECEIVED

03508

## CERTIFICATE OF DEATH

Reg. Dist. No.

353

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishop</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishop</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bishop</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Elizabeth</b> Last <b>McGregor</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1910</b>	
9. AGE (In years last birthday) <b>46</b>		IF UNDER 1 YEAR Months <b>46</b> Days <b>19</b> Hours <b>57</b> Min.		IF UNDER 24 HRS. Months <b>46</b> Days <b>19</b> Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Lamay Ayres</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Robbins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-34-2940</b>		17. INFORMANT <b>Louise Showell</b> Address <b>Bishop, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential hypertension</b> DUE TO (c) <b>3 mos</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/3</b> , 19 <b>56</b> , to <b>3/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/1</b> , 19 <b>57</b> , and that death occurred at <b>9:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry U. Shelby Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Berlin, Md.</b>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <b>3/8/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Watson</b> ADDRESS <b>Pocomoke City, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 121957</b>		24b. REGISTRAR'S SIGNATURE <b>Hilda Rye</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 12 1957

RECEIVED

03509

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertie T. Paradee				4. DATE OF DEATH Month Day Year March 22 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 19, 1871	
9. AGE (In years lost birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John S. Johnson				14. MOTHER'S MAIDEN NAME Hester Jane Aydolotte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT E. T. Paradee, Stockton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Enterio-sclerotic Myocardial (c) Nephritic disease DUE TO Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 2 years 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept 1956, to 3/22/57 19, that I last saw the deceased alive on 3/21/57 19, and that death occurred at 1:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Paul Cohen				M.D.			
PHYSICIAN'S NAME (Type) Paul Cohen				Snow Hill, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-57		22c. NAME OF CEMETERY OR CREMATORY Goodwill M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Rural Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke Md.		24a. REC'D BY REGISTRAR DATE 3/27/57	
				24b. REGISTRAR'S SIGNATURE Anne White			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03510

CERTIFICATE OF DEATH

Reg. Dist. No. 0351455

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Berlin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Berlin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 William St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>Jane</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Loretta, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hampton H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Emily Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MRS. Lucy Collins Berlin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema + Anasarca.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Chronic Myocarditis</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>18 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Mar 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>18 March</u> , 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>						DATE SIGNED	
ACTUAL SIGNATURE <u>Hermauld Koller</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Hermauld Koller</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 21</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 3-20-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. OCCUPATION		6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH	
9. CAUSE OF DEATH		10. MEDICAL ATTENDANT		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESSES	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF DECEASED		28. SIGNATURE OF WITNESSES	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESSES		31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESSES		35. SIGNATURE OF DECEASED		36. SIGNATURE OF WITNESSES	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF DECEASED		40. SIGNATURE OF WITNESSES	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESSES	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF WITNESSES		47. SIGNATURE OF DECEASED		48. SIGNATURE OF WITNESSES	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESSES	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESSES		55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESSES	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESSES		59. SIGNATURE OF DECEASED		60. SIGNATURE OF WITNESSES	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF DECEASED		64. SIGNATURE OF WITNESSES	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF WITNESSES		67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESSES	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESSES		71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESSES	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF DECEASED		76. SIGNATURE OF WITNESSES	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESSES		79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESSES	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESSES		83. SIGNATURE OF DECEASED		84. SIGNATURE OF WITNESSES	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF DECEASED		88. SIGNATURE OF WITNESSES	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESSES		91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESSES		95. SIGNATURE OF DECEASED		96. SIGNATURE OF WITNESSES	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF DECEASED		100. SIGNATURE OF WITNESSES	

BUREAU V. S.

MAR 22 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03515

## CERTIFICATE OF DEATH

Reg. Dist. No. 257

03511

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Worcester</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Snow Hill</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Federal St</b>				STREET ADDRESS <b>Federal St.</b>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>ISAAC THOMAS SMULLEN</b>				<b>4. DATE OF DEATH</b> (Month) <b>MARCH</b> (Day) <b>24th</b> (Year) <b>19 57</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>August 27, 1873</b>	<b>9. AGE last birthday</b> <b>83</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Worcester Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Elijah Henry Smullen</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Frances Lokey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Vina Perdue (Sister) Federal St. Snow Hill, Maryland</b>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>453.8 IMMEDIATE CAUSE (A)</b> <b>Cachexia and Emaciation</b>				<b>1 month</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arteriosclerosis + Peripheral Vascular Disease</b>				<b>5 yrs</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>slm gangrene Left leg due to occlusion of Left subcl</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>popliteal artery</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b> (County) (State)			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>June</u> 19 <u>50</u>, to <u>March 24</u>, 19 <u>57</u>, that I last saw the deceased alive on <u>March 24</u>, 19 <u>57</u>, and that death occurred at <u>10:30P</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>J. Baugh</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Snow Hill, Maryland</b> <b>DATE SIGNED</b> <b>3/26/57</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial-</b>		<b>DATE THEREOF</b> <b>Mar. 27, 1957</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Smullen Cemetery</b>		<b>LOCATION (City, town, or county)</b> (State) <b>Worcester Co. Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>MAR 29 1957</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elwyn Cooper</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 5

MAR 29 1957

RECEIVED



03512

## CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. LENGTH OF STAY IN 1b <u>16 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Capt Samuel M Stevens</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6 - 1886</u>	
9. AGE (in years last birthday) <u>70-6-27</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Capt U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Warrior Illinois</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John H. Stevens</u>			
14. MOTHER'S MAIDEN NAME <u>Lina May Mussetter</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give year or date of service) <u>1903 to 1946</u>			
16. SOCIAL SECURITY NO. <u>1903 5 1946</u>				17. INFORMANT <u>Capt J. D. Stevens</u> Address <u>116 Manner Base Quantico Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>March 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>57</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph L. Lamar</u> M.D.				DATE SIGNED <u>104 Bay St</u> <u>3-4-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M. D.</u>				ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 5 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Academy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Lewis</u> ADDRESS <u>Snow Hill, Md.</u>				24. REC'D BY REGISTRAR <u>Mar 6 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Clayton E. Lewis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAR 6 1957

RECEIVED

03513

CERTIFICATE OF DEATH

Reg. Dist. No. 04665 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Rural Area</u>		STATE <u>Ga.</u> COUNTY <u>Coffie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Douglas, Ga.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		606 Shirley Ave. 49X-3	
3. NAME OF DECEASED: (First) <u>Cleveland</u> (Middle) <u>Sykes</u> (Last) <u>Sykes</u>				4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>29</u> (Year) <u>1957</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 8-1891</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Ministry</u>		11. BIRTHPLACE (State or foreign country): <u>Whitesville, N.C.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Sykes</u>				14. MOTHER'S MAIDEN NAME: <u>Rosanna - Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.: <u>252-18-673</u>		17. INFORMANT'S ADDRESS: <u>Shirley May Sykes - daughter</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 1/2 years	
151X IMMEDIATE CAUSE (A) DUE TO <u>Cancer Stomach</u>							
ANTECEDENT CAUSE (B) DUE TO <u>Ulcer Stomach</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)						Several years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 26, 1957</u> to <u>March 26, 1957</u> , that I last saw the deceased alive on <u>March 26, 1957</u> , and that death occurred at <u>4:57 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W.E. Sartorius Sr.</u>		M.D. <u>Pocomoke City Md.</u>		DATE SIGNED <u>3/29/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-7-57</u>		NAME OF CEMETERY OR CREMATORY <u>St. James</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Apr. 8, 1957</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>		24. FUNERAL DIRECTOR <u>Edgar Wharton - New Church, Va.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

APR 15 1957

RECEIVED

03514

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>43 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 N. MAIN ST.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED AMELIA TRUITT</u>				4. DATE OF DEATH Month Day Year <u>MAR 30 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 2, 1914</u>		9. AGE (In years lost birthday) <u>42 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PARSONSBURG, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LELAND HASTINGS</u>				14. MOTHER'S MAIDEN NAME <u>IDA DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. KENDALL TRUITT</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Cervix of Uterus - Small Intestine</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Metastasis, Acute</u> DUE TO (c) <u>Uremia due to closure of Ureter</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 mo., 48 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15, 1952</u> , to <u>Mar 30, 1957</u> , that I last saw the deceased alive on <u>Mar 30, 1957</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>3/30/57</u>							
ACTUAL SIGNATURE <u>Bernard Rabus</u> M.D.				PHYSICIAN'S NAME (Type) <u>Bernard Rabus</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>Helen F Hayward</u> DATE <u>4-1-57</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

APR 2 1957

RECEIVED

03494

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>604 Market Street</u>				d. STREET ADDRESS <u>604 Market Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William M. Walsh</u>				4. DATE OF DEATH Month Day Year <u>March 9 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1882</u>		9. AGE (In years last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Ass't Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William M. Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Annie F. Walsh, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, ACUTE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>15 YEARS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pocomoke City Worcester Md.</u>	
20f. (City or town) <u>Pocomoke City</u>				20g. (County) <u>Worcester</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>3-9</u> , 19 <u>57</u> , to <u>3-9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>57</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Stanford Hamilton</u> M.D.				ADDRESS (Street, city or town, state) <u>Pocomoke City</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>C. STANFORD HAMILTON</u>				<u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem M.E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 12 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ann White</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 104-10

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 13 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Rural Pocomoke City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD #3</b>				d. STREET ADDRESS <b>1 RFD #3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mae</b> Last <b>Ward</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 25, 1882</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Dryden</b>				14. MOTHER'S MAIDEN NAME <b>Mary Carter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Claude Ward, RFD #3, Pocomoke, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/14</b> , 19 <b>57</b> , to <b>3/21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/21</b> , 19 <b>57</b> , and that death occurred at <b>2:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>312 E. Market St., Snow Hill, Md.</b> DATE SIGNED <b>3/22/57</b>							
ACTUAL SIGNATURE <b>Thomas L. Jones, MD</b>		PHYSICIAN'S NAME (Type) <b>THOMAS L. JONES</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Goodwill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Pocomoke, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry B. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 26 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Anne White</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 28 1957